VERMONT
DEPARTMENT OF HEALTH

# Hepatitis C Report Form

**Health Department Internal Use**

| | |
|---|---|
| Investigation started | ____/____/___ |
| Contact with patient | ☐Yes ☐No |
| Date of contact | ____/____/___ |
| Case status updated | ____/____/___ |
| Notification sent | ____/____/___ |

## Patient:

Patient Name:_____

DOB:_____/_____/_____ Sex: ☐Male ☐Female

Home Phone:_____

Address:_____

**REQUIRED:** Town:_____ County: _____

**Race: (circle all that apply):**

☐White ☐African American ☐Native American ☐Hawaiian/Pacific Islander ☐Asian ☐Other_____

**Ethnicity:** ☐Hispanic ☐Non-Hispanic

**Provider:**

Ordering Provider:_____ Phone:_____

Provider Practice:_____

Specimen collected____/____/____ Lab Report Date____/____/____ Reported to VDH:____/____/____

| **Hepatitis C Tests:** | Positive | Negative | Unknown | Date |
|---|---|---|---|---|
| **1.** Antibody Test (anti-HCV by EIA) | ☐ | ☐ | ☐ | ____/____/___ |
| **2**. Supplemental anti-HCV assay (eg RIBA) | ☐ | ☐ | ☐ | ____/____/___ |
| **3.** HCV RNA (eg PCR) | ☐ | ☐ | ☐ | ____/____/___ |
| **4**. HCV antigen tests | ☐ | ☐ | ☐ | ____/____/___ |
| **5**. HCV Genotype Testing Type_____ | ☐ | ☐ | ☐ | ____/____/___ |
| **6.** Previous negative HCV antibody test within 12 mos. | ☐Yes | ☐No | ☐Unknown | ____/____/___ |

**7.** Liver Enzyme levels: ALT/SPGT: _____ AST/GOT:_____

**REQUIRED: HCV Classification** (refer to numbered Hepatitis C Tests listed above and clinical criteria* below)

☐**Acute HCV, Confirmed:** Meets clinical criteria* and has Positive 3 or 4 **or** positive tests 1,2,3,or 4 and 'yes' to 6

☐**Acute HCV, Probable:** Meets clinical criteria*, positive tests 1 or 2, and 'no' to 6

☐**Chronic HCV, Confirmed:** Does not meet clinical criteria*, has positive 3 or 4, and 'no' to 6

☐**Chronic HCV, Probable:** Does not meet clinical criteria*, has positive 1 or 2, and 'no' to 6

***Clinical Criteria** (must meet a. and either b. or c. criteria)

a.) An illness with discrete onset of any sign or symptom consistent with acute viral hepatitis: ☐Yes ☐No - If 'yes' please check: ☐Fever, ☐Headache, ☐Malaise, ☐Anorexia, ☐Nausea, ☐ Vomiting, ☐Diarrhea, ☐Abdominal pain, ☐Other_____

**AND**

b.) Jaundice: ☐Yes ☐No - If 'yes', date of onset ____/____/____

**OR**

c.) A peak elevated serum ALT level >200 IU/L during the period of acute illness

| **Other Hepatitis Tests:** | Positive | Negative | Unknown | Date |
|---|---|---|---|---|
| IgM antibody to hepatitis A | ☐ | ☐ | ☐ | ____/____/___ |
| Hepatitis B surface antigen (HbsAg) | ☐ | ☐ | ☐ | ____/____/___ |
| Total antibody to hepatitis B core antigen (anti-HBc) | ☐ | ☐ | ☐ | ____/____/___ |

Other:_____

To return this form: SECURE FAX: 802-951-4061
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Questions: Roy Belcher, 802 951 4065

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